Washington Rural Health Quality Network Field Test

ER Chest Pain/AMI Tool

Provider Name: _____ **Provider Medicare #:** _____

Patient's First Name: _____ **Patient's Last Name:** _____

ICD-9-CM Principal Diagnosis Code: ___ ___ ___ . ___ ___

*(If the selected code is not listed in the AMI Data Abstraction Definitions, **STOP ABSTRACTION.**)*

ICD-9-CM Other Diagnosis Code

___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___

___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___

___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___

Was the patient's condition presumed to be cardiac in origin?

Yes _____
No _____ **(STOP ABSTRACTION.)**
UTD _____

DOB: __ __ / __ __ / __ __ __ __

Sex: _____ Male _____ Female

Zip Code: _____

Medical Record #: _____

Social Security #: _____

Medicare/HIC #: _____

Race: (*Select one)*
_____ Black or African American
_____ American Indian/Alaska Native
_____ Asian
_____ White
_____ Native Hawaiian/Pacific Islander
_____ UTD

Hispanic Ethnicity:
_____ Yes
_____ No/UTD

Payment Source: (*Select all that apply)*
_____ Medicare
_____ Medicaid
_____ Other (e.g., Veteran Administration (VA), CHAMPUS, Workers' Compensation, or private insurance)
_____ No insurance/Not documented/UTD

Admission Source
(Select one option)

_____1 = Physician referral
_____2 = Clinic referral
_____3 = HMO referral
_____4 = Transfer from a hospital **STOP ABSTRACTION**
_____5 = Transfer from skilled nursing facility
_____6 = Transfer from another health care facility
_____8 = Court/law enforcement
_____9 = Information not available
_____A = Transfer from a critical access hospital **STOP ABSTRACTION**
_____B = From home

Did the patient arrive by ambulance?
_____ Yes
_____ No

Arrival date: __ __ / __ __ / __ __ __ __ **Arrival time:** __ __ __ __ (military time)

Discharge date: __ __ / __ __ / __ __ __ __ **Discharge time:** __ __ __ __ (military time)

Discharge Status
(Select one option)

____01 = Discharged to home care or self care (routine discharge)
____02 = Discharged/transferred to another short term general hospital for inpatient care
____03 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification
____04 = Discharged/transferred to an intermediate care facility (ICF)
____05 = Discharged/transferred to another type of institution for inpatient care
____06 = Discharged/transferred to home under the care of organized home health service organization
____07 = Left against medical advice or discontinued care
____08 = Discharged/transferred to home under care of home IV provider
____09 = Admitted as an inpatient to this hospital
____20 = Expired
____41 = Hospice patients who expired in a medical facility such as hospital, SNF, ICF or freestanding hospice
____43 = Discharged/transferred to a federal health care facility
____50 = Hospice – home
____51 = Hospice - medical facility
____61 = Discharged/transferred within this institution to hospital-based Medicare approved swing bed
____62 = Discharged/transferred to an inpatient certified rehabilitation facility (IRF) including rehabilitation distinct units of a hospital
____63 = Discharged/transferred to a Medicare certified long term care hospital (LTCH)
____64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
____65 = Discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital

DIAGNOSTIC TESTS

1. **Was a 12-lead electrocardiogram (ECG/EKG) done within 1 hour prior to hospital arrival?**
   ____ Yes
   ____ No **(Go to #4)**

2. **What was the date of the pre-arrival 12-lead electrocardiogram (ECG/EKG) done closest to the time of hospital arrival?**
   ___ ___ / ___ ___ / ___ ___ ___ ___

3. **What was the time of the pre-arrival 12-lead electrocardiogram (ECG/EKG) done closest to the time of hospital arrival?**
   ___ ___ ___ ___ (military time)

4. **Was a 12-lead electrocardiogram (ECG/EKG) done after hospital arrival?**
   ____ Yes
   ____ No **(Go to #7)**

5. **What was the date of the first 12-lead electrocardiogram (ECG/EKG) done after hospital arrival?**
   ___ ___ / ___ ___ / ___ ___ ___ ___

6. **What was the time of the first 12-lead electrocardiogram (ECG/EKG) done after hospital arrival?**
   ___ ___ ___ ___ (military time)

MEDICATIONS

7. **Was thrombolytic therapy received during this ER stay?**
   ____ Yes
   ____ No **(Go to # 10)**

8. **What was the date thrombolytic therapy was initiated during this ER stay?**
   ____ ____ /____ ____ / ____ ____ ____ ____

9. **What was the time thrombolytic therapy was initiated during this ER stay?**
   ___ ___ ___ ___ (military time)

10. Was aspirin received within 24 hours before hospital arrival?

____ Yes
____ No

11. Was aspirin received during this ER stay?

____ Yes
____ No **(Go to #14)**

12. What was the date aspirin was received during this ER stay?

____ ____ /____ ____ / ____ ____ ____ ____

13. What was the time aspirin was received during this ER stay?

___ ___ ___ ___ (military time)

14. Is one or more of the following potential contraindications/reasons for not prescribing aspirin present on arrival?

- ACTIVE bleeding on arrival or during this ER stay
- Aspirin allergy
- Warfarin/Coumadin as pre-arrival medication
- Other reason documented by physician, nurse practitioner, or physician assistant for not prescribing aspirin on arrival

____ Yes
____ No